MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP ( ) IE ( ) IC	**Response Timely Filed?** ( ) Yes (X) No
Requestor Harris Methodist Ft. Worth P.O. Box 916063 Ft. Worth, TX 76191-6063	MDR Tracking No.: M4-03-8429-01 TWCC No.: Injured Employee's Name:
Respondent Valiant Insurance Co. Rep. Box #19	Date of Injury: Employer's Name: Frank Bartel & Sons Truck Inc. Insurance Carrier's No.: 2230104574

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
10-30-02	11-25-02	Inpatient Hospitalization	132,380.41	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

Not all charges were considered the Trauma codes were not considered. The total chg wasn't even pd at 75%. Please review for additional pymts being trauma and physical therapy wasn't considered.

PART IV: RESPONDENT'S POSITION SUMMARY

Position statement was not submitted.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to inpatient services provided in a hospital setting with reimbursement subject to the provisions of Rule 134.401 (Acute Care Inpatient Hospital Fee Guideline). In this particular admission, the principle diagnosis code was 807.09 related to trauma care for closed fracture multiple ribs, traumatic subcutaneous emphysema, traumatic hemothorax closed and acute respiratory failure. Pursuant to Rule 134.401(c)(5), the reimbursement for the entire admission shall be paid at a fair and reasonable rate.

Determining the "fair and reasonable" reimbursement can be difficult. In this case, it appears that neither the requestor nor the respondent have persuasively shown that their position represents the appropriate amount. Therefore, an alternate approach is needed to determine the reimbursement amount.

Based on the data contained in the Commission's medical billing database for dates of service in 2002, trauma admissions were reimbursed, on average, at 55.5% of the total charges (total payments divided by total charges). Applying this same formula to this specific case appears to be a sound method to determine the appropriate fair and reasonable reimbursement.

Accordingly, the health care provider is entitled to a total reimbursement amount of $75,035.51. This was calculated by multiplying the total changes of $135,199.13 by 55.5%.

Since the carrier has previously paid $97,224.10, additional reimbursement is not due.

Considering the reimbursement amount calculated in accordance with the provisions of rule 134.401 compared with the amount previously paid by the insurance carrier, we find that no additional reimbursement is due for these services.

PART VI: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to additional reimbursement.

Decision by:

	Elizabeth Pickle	May 26, 2005
Authorized Signature	Typed Name	Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____